BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Philip Albert Sanderson, M.D.	)	**Case No. 800-2016-024913**
Physician's and Surgeon's Certificate No. A 42137	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 22, 2019.

IT IS SO ORDERED August 15, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer
Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PHILIP ALBERT SANDERSON, M.D.** **380 Stevens Avenue, Suite 100** **Solana Beach, CA 92075-2068** **Physician's and Surgeon's Certificate No. A 42137** Respondent.	Case No. 800-2016-024913 OAH No. 2018120742 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by LeAnna E. Shields, Deputy Attorney General.

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2. Philip Albert Sanderson, M.D. (Respondent) is represented in this proceeding by attorney Robert W. Frank, Esq., with Neil, Dymott, Frank, McCabe & Hudson, APLC, whose address is 110 West A Street, Suite 1200, San Diego, California 92101.

3. On or about September 16, 1985, the Board issued Physician's and Surgeon's Certificate No. A 42137 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-024913 and expired on June 30, 2019, and has not been renewed.

JURISDICTION

4. On September 6, 2018, Accusation No. 800-2016-024913 was filed before the Board, and is currently pending against Respondent. A true and correct copy of Accusation No. 800-2016-024913 and all other statutorily required documents were properly served on Respondent on September 6, 2018. Respondent timely filed his Notice of Defense. A true and correct copy of Accusation No. 800-2016-024913 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2016-024913. Respondent also has carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to all the charges and allegations contained in Accusation No. 800-2016-024913, that he has thereby subjected his Physician's and Surgeon's Certificate No. A 42137 to disciplinary action, and hereby surrenders his Physician's and Surgeon's Certificate No. A 42137 for the Board's formal acceptance.

9. Respondent agrees that if he files a petition for reinstatement or relicensure, or an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2016-024913 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate No. A 42137 without notice to, or opportunity to be heard by, Respondent.

CONTINGENCY

11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

12. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A 42137, without further notice to, or opportunity to be heard by, Respondent.

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands

and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

16. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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17. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 42137, issued to Respondent Philip Albert Sanderson, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate No. A 42137 and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2016-024913 shall be deemed to be true, correct and fully admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2016-024913 shall be deemed to be true, correct, and fully admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Robert W. Frank, Esq., and I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 42137. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 9 July 2019

PHILIP ALBERT SANDERSON, M.D.
Respondent

I have read and fully discussed with Respondent Philip Albert Sanderson, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 7-10-19

ROBERT W. FRANK, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: July 10, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

LEANNA E. SHIELDS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-024913

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PHILIP ALBERT SANDERSON, M.D.** **380 Stevens Avenue, Suite 100** **Solana Beach, CA 92075-2068** **Physician's and Surgeon's Certificate No. A 42137,** Respondent.	Case No. 800-2016-024913 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 16, 1985, the Medical Board issued Physician's and Surgeon's Certificate No. A 42137 to Philip Albert Sanderson, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"..."

6. Section 2242 of the Code states, in pertinent part:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"..."

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7. Section 4022 of the Code states, in pertinent part:

"'Dangerous Drug' ... includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import."

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

8. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 42137 to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A, B, C and D,[1] as more particularly alleged hereinafter:[2]

Patient A

10. In or around 2009, Respondent began treating Patient A for, among other things, attention deficit disorder (ADD), depression, anxiety, and chronic back and neck pain. From on or about 2009 through on or about 2016, Respondent prescribed several controlled substances to

[1] To protect the privacy of all patients involved, patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

Patient A, including, but not limited to, Duragesic,[3] Norco,[4] Adderall,[5] alprazolam,[6] Soma[7] and oxycodone.[8]

11. During the period from on or about 2009 through on or about 2016, medical records show Patient A was issued medication refills approximately every three months. In general, the progress notes for these visits are incomplete in that they lack adequate detail regarding medical indication for prescribing controlled medications, treatment plan, or rationale for

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[3] Duragesic is a brand name for fentanyl, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Fentanyl is a potent synthetic opioid drug. When properly prescribed and indicated, it is used for the treatment of pain relief. It is approximately 100 times more potent than morphine. Fentanyl is available as a transdermal patch (Duragesic) and as an oral transmucosal lozenge, commonly referred to as fentanyl lollipops (brand name Actiq). (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 40.)

[4] Norco is a brand name for hydrocodone/acetaminophen combination. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The DEA has identified opioids, such as Hydrocodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.) For example, Vicodin, Lortab, and Norco are brand names for the drug combination of hydrocodone bitartrate-acetaminophen, which is commonly prescribed under the generic name of Hydrocodone/APAP.

[5] Adderall is a brand name for dextroamphetamine and amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of attention-deficit hyperactivity disorder and narcolepsy. Adderall carries a black box warning indicating that it has high abuse potential.

[6] Alprazolam is a brand name for Xanax, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Alprazolam is a short-acting benzodiazepine. When properly prescribed and indicated, it is commonly used to relieve anxiety.

[7] Soma is a brand name for Carisoprodol, a Schedule IV controlled substance pursuant to 21 C.F.R. § 1308.14, and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used as a muscle relaxant. According to the DEA, Office of Diversion Control, published comment on Carisoprodol, dated March 2014, "[c]arisoprodol abuse has escalated in the last decade in the United States...According to Diversion Drug Trends, published by the Drug Enforcement Administration (DEA) on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs."

[8] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The Drug Enforcement Administration (DEA) has identified opioids, such as Oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.)

continued prescribing high amounts of benzodiazepines[9] and opiates simultaneously.[10] Additionally, there is no documentation of informed consent obtained prior to beginning treatment with controlled substances, there is no evidence Respondent was monitoring for aberrant behavior, and a pain contract is not entered into until July 2014.

12. In or around 2009, Respondent was prescribing Patient A with Adderall at a dose of approximately 50 mg per day, in addition to hydrocodone.

13. In or around 2010, Respondent continued to prescribe Patient A with Adderall at a dose of approximately 50 mg per day, in addition to Soma, Xanax, and Abilify.[11]

14. In or around 2011, Respondent continued to prescribe Patient A with Adderall at a dose of approximately 60 mg per day, and had increased Patient A's Adderall to 90 mg per day by the end of 2011.

15. In or around 2012, Patient A presented for office visits on February 2, May 8, June 7, July 30, August 28, and December 18. At each visit, Respondent continued to prescribe Patient A with Adderall (30 mg) three per day, in addition to Norco (5/325) two per day, Soma (350 mg) one or two per day, Abilify and Paxil.

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[9] Benzodiazepines (e.g., Lorazepam, Temazepam, and Diazepam) are Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and are dangerous drugs pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, they are used for the management of anxiety disorders or for the short-term relief of anxiety. Opioids (e.g., hydrocodone, fentanyl, methadone, and oxycodone) are Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (c), and are dangerous drugs pursuant to Business and Professions Code section 4011. When properly prescribed and indicated, they are generally used for pain management.

[10] All opioids carry a Black Box Warning that states, in part, "assess opioid abuse or addiction risk prior to prescribing; monitor all patients for misuse, abuse, and addiction." The combination of opioids with benzodiazepines is among the most common causes of death due to prescription drug overdose. The Black Box Warning for opioids states, "Concomitant opioid use with benzodiazepines... may result in profound sedation, respiratory depression, coma, and death; reserve concomitant use for patients with inadequate alternative treatment options; limit to minimum required dosage and duration."

[11] Abilify is a brand name for aripiprazole, a dangerous drug pursuant to Business and Professions Code section 4022. Abilify is an antipsychotic medication commonly used to treat symptoms of schizophrenia and bipolar disorder. It has an additive CNS depressant effect with opiates, benzodiazepines, and muscle relaxers.

16. On or about March 14, 2013, Patient A presented requesting a refill of her medications. During this visit, Patient A mentioned ongoing issues with the pharmacy regarding her Adderall prescriptions. Progress notes for this visit indicate Respondent continued to prescribe Patient A with Norco (5/325) four per day and Adderall (30 mg) three per day. However, according to the Controlled Substance Utilization Review and Evaluation System[12] (CURES) report for Patient A, Respondent prescribed Adderall (30 mg) four per day, for a total of 120 mg per day.

17. On or about June 10, 2013 and September 12, 2013, Patient A presented requesting a refill of her medications. Progress notes for these visits do not indicate the Adderall dose or Norco dose prescribed to Patient A, only that her Adderall and Norco medications were refilled.

18. On or about November 28, 2013, according to CURES, Respondent increased Patient A's prescription from Norco dosage from 5 mg two per day, to 10 mg two per day. However, there is no progress note showing any patient visit for November 2013 to document the reason for this increase.

19. According to CURES, on or about December 2, 2013, Patient A filled a prescription by another physician, B.G., for 60 tablets of Soma (350 mg).

20. On or about December 10, 2013, Respondent continued to prescribe Adderall and Norco. Progress notes for this visit do not indicate the Adderall dose or Norco dose prescribed to Patient A, only that her Adderall and Norco medications were refilled.

21. According to CURES, on or about January 6, 2014 and January 8, 2014, Patient A filled prescriptions by another physician, B.G., for 240 tablets of Norco (10/325), 4 tablets of

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[12] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

diazepam, 60 tablets of Soma (350 mg), 120 tablets of Adderall (30 mg), and 30 tablets of alprazolam (0.5 mg).

22. On or about March 11, 2014, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent refilled Adderall and Norco, but no dosage information is provided for either the Adderall or Norco. However, progress notes indicate Patient A was advised Respondent would begin issuing prescriptions for only four weeks, rather than three months at a time.

23. On or about April 1, 2014, Patient A filled a prescription by another physician, B.G., for 60 tablets of Soma (350 mg).

24. On or about April 25, 2014, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent refilled Patient A's Adderall prescription, with no dosage indicated, and Norco (10/325) four per day, for three months (120 tablets per month, for a total of 480 tablets of Norco).

25. On or about May 15, 2014, Patient A filled prescriptions by another physician, B.G., for 30 tablets of alprazolam (0.5 mg), 60 tablets of Soma (350 mg), 120 tablets of Norco (10/325), and 120 tablets of Adderall (30 mg).

26. On or about June 9, 2014, Patient A filled a prescription by another physician, B.G., for 60 tablets of Soma (350 mg).

27. On or about June 23, 2014, Patient A filled a prescription by another physician, B.G., for 120 tablets of Norco (10/325).

28. On or about July 3, 2014, Patient A presented requesting an early refill of her medications and reported losing "the end of her opiate prescription." Progress notes for this visit indicate Patient A had been taking "hefty doses of Norco over the years... taking 10 tablets a day, which is a bit over the top in terms of her Tylenol exposure... and is on hefty doses of Adderall." Progress notes indicate Respondent held a lengthy discussion with Patient A regarding management of her medications, reviewed a patient pain medication agreement, and that Patient A signed the pain agreement. Respondent also indicated a plan to reduce Patient A's Norco

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prescription to five tablets per day, with the addition of fentanyl.[13] Patient A's Adderall prescription continued unchanged.

29. The Pain Agreement signed on or about July 3, 2014 by Respondent and Patient A, in part, specifically prohibited early refills, the use of more than one pharmacy, the use of other clinics to obtain pain medications, and an agreement to random drug testing.

30. On or about July 9, 2014, Patient A filled prescriptions by another physician, B.G., for 30 tablets of alprazolam (0.5 mg) and 60 tablets of Soma (350 mg).

31. On or about August 4, 2014, Patient A filled a prescription by another physician, B.G., for 60 tablets of Soma (350 mg).

32. On or about August 18, 2014, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent's plan to continue prescribing fentanyl to Patient A and only using hydrocodone intermittently, as necessary.

33. On or about September 4, 2014, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Patient A was able to maintain her hydrocodone use to five tablets. Respondent refilled Patient A's medications.

34. On or about October 10, 2014, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Patient A requested and received refills for three months' supply of Adderall XR[14] (30 mg), Adderall (30 mg), Norco (10/325), and fentanyl. Progress notes for this visit also indicate Respondent's plan to reduce Patient A's Adderall and Norco doses.

35. On or about December 16, 2014, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent's plan for Patient A was to "slowly come down off of the hydrocodone and count on the fentanyl."

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[13] Fentanyl, brand name Duragesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Fentanyl is a potent opioid. In general, 1 mcg per hour of fentanyl is approximately equivalent to 2.4 morphine milligram equivalent in a 24-hour period.

[14] Adderall XR, is the extended release version of Adderall. See footnote 5 (above).

36. On or about March 27, 2015, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent's plan for Patient A was to continue to slowly reduce Patient A's hydrocodone and rely on fentanyl.

37. On or about May 12, 2015, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent's plan to lower Patient A's hydrocodone intake, however, "she is motivated to stay where she is" and that Respondent refilled Patient A's medications unchanged for the next three months.

38. On or about August 24, 2015, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent's plan to reduce Patient A's hydrocodone intake from four per day to three per day, but then to increase the content to 7.5 mg. Progress notes further indicate Patient A reported having issues with the fentanyl patches lifting from her skin, such that she was unable to get the full dose from each patch, and Patient A's fear of reducing her medication, reporting that when she runs short, her symptoms return. Progress notes also indicate Respondent's plan to lower Patient A's Adderall dose.

39. On or about September 8, 2015, Patient A reported her fentanyl patches continued to lift off her skin. Respondent then prescribed Patient A methadone[15] (10 mg) every 12 hours.

40. On or about October 9, 2015, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent reviewed his pain management treatment goals with Patient A, and Respondent's plan to continue prescribing methadone to Patient A while reducing Patient A's fentanyl and hydrocodone doses.

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[15] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Methadone is a potent long-acting synthetic opioid, indicated for use only in opiate tolerant patients. Methadone is rapidly orally absorbed, therefore having an analgesic effect within 30 minutes of oral administration. However, it's peak opiate effect is often not attained for 3 to 5 days. Therefore, Methadone is never to be prescribed with a variable or flexible dose regimen, and is only to be prescribed with a fixed dosing schedule, under close supervision, and only after careful patient instruction regarding the potentially lethal consequences of self-adjustment of dosage.

41. On or about December 3, 2015, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Patient A was doing better with the addition of methadone and reducing her fentanyl dose.

42. On or about February 8, 2016, Patient A presented requesting a refill of her medications. Progress notes for this visit indicate Respondent refilled Patient A's medications without any change in dose or amount.

43. On or about May 6, 2016, Patient A presented for her final visit with Respondent. Progress notes for this visit indicate Respondent again discussed the need to reduce Patient A's medications. Respondent then refilled Patient A's medications without any change in dose or amount and also issued a prescription for Oxycodone IR (30 mg) without documenting any reason or plan.

44. Despite the repeated documentation of Respondent's plan to reduce Patient A's medications, Respondent continued to issue prescriptions for Adderall, fentanyl and Norco with no significant change in dose or amount. Additionally, Respondent issued prescriptions to Patient A for methadone and Oxycodone.

45. When asked about how he determined the starting dose for fentanyl for Patient A during a subject interview at the Department of Consumer Affairs Health Quality Investigation Unit, Respondent stated, "Just out of the air... seemed a reasonable amount."

46. When asked about his prescribing pattern to Patient A, Respondent admitted he was not aware Patient A was obtaining medications from several different pharmacies, he was not aware Patient A was also obtaining prescriptions for similar medications from another physician, B.G., he failed to obtain urine drug screens from Patient A, and that he never calculated the total morphine equivalent dose (MED)[16] for the medications prescribed to Patient A.

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[16] Morphine Equivalent Dose (MED), also commonly referred to as Morphine Milligram Equivalent (MME), is used to equate different opioids into one standard value, based on morphine and its potency, referred to as MED or MME. MED/MME calculations permit all opioids to be converted to an equivalent of one medication, for ease of comparison and risk evaluations. In general, the standard of practice is to limit a patient's opioid dose to less than 50 MED/MME in most patients receiving opioid treatment for chronic pain, and to exceed 90 MED/MME in only the most unusual circumstances.

47. At no time during his care and treatment of Patient A, did Respondent recognize or document an adequate response to Patient A's aberrant drug behavior. A pain agreement was not discussed or entered into until July 2014. Despite entering into the pain agreement, Respondent failed to discover Patient A continued obtaining and receiving controlled substances from multiple pharmacies and another physician.

48. According to the CURES report for Patient A, from on or about November 2013 through on or about November 2016, Patient A was filling prescriptions at approximately seven different pharmacies.

49. According to the CURES report for Patient A, from on or about July 2014 through on or about July 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 260 Duragesic fentanyl patches (75 mcg per hour).

50. According to the CURES report for Patient A, from on or about September 2015 through on or about April 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 480 tablets of Methadone (10 mg).

51. According to the CURES report for Patient A, from on or about January 2013 through on or about April 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 6,150 tablets of Norco (5-10 mg).

52. According to the CURES report for Patient A, from on or about January 2013 through on or about July 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 4,554 tablets of Adderall (30 mg).

53. According to the CURES report for Patient A, from on or about January 2013 through on or about October 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 1,290 tablets of alprazolam.

54. According to the CURES report for Patient A, from on or about January 2013 through on or about August 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient A obtained approximately 1,860 tablets of Soma (350 mg).

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55. Respondent committed gross negligence in his care and treatment of Patient A, which included, but were not limited to, the following:

(a) Respondent failed to obtain and document informed consent prior to prescribing controlled substances to Patient A;

(b) Respondent failed to maintain a high degree of diligence for aberrant drug behavior and failed to recognize red flag behavior;

(c) Respondent failed to take active steps to determine whether Patient A was receiving controlled substances from other providers;

(d) Respondent failed to discover Patient A was receiving controlled substances from another physician;

(e) Respondent failed to recognize dose escalation as a warning sign of aberrant drug behavior;

(f) Respondent escalated the dose of opioids to Patient A while documenting his intent to reduce Patient A's opioid dose;

(g) Respondent failed to use dose calculation based upon total daily dose of short acting opioids when beginning Patient A's initial fentanyl dose;

(h) Respondent failed to take positive control over Patient A's dose and use of Adderall;

(i) Respondent failed to identify the intended dose of Patient A's Adderall prescription in his progress notes;

(j) Respondent continually prescribed a combination of benzodiazepines and opioids to Patient A without any documentation or plan to monitor for possible adverse events; and

(k) Respondent failed to support or document in his medical records the care and treatment provided to Patient A.

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Patient B

56. In or around 2011, Respondent began treating Patient B for, among other things, anxiety, depression, fibromyalgia, chronic pain, attention deficit hyperactivity disorder (ADHD), insomnia, gastroesophageal reflux disease (GERD), and migraine headaches. From on or about 2011 through on or about 2016, Respondent prescribed several controlled substances to Patient B, including, but not limited to, oxycodone, alprazolam, Adderall, temazepam[17] and Ambien.[18]

57. During the period from on or about January 2013 through on or about March 2016, medical records show Patient B was issued medication refills approximately every three months. In general, the progress notes for these visits are incomplete in that they lack adequate detail regarding physical examination, medical indication for prescribing controlled medications, treatment plan, or rationale for continued prescribing high amounts of benzodiazepines and opiates simultaneously. Additionally, there is not documentation of informed consent obtained prior to beginning treatment with controlled substances, there is no evidence Respondent was monitoring for aberrant behavior, and a pain contract is not entered into until July 2014.

58. On or about March 7, 2011, Patient B called in requesting an "early refill" of her medications, stating she would be going out of town. Respondent issued the requested refills for oxycodone, alprazolam, and temazepam.

59. On or about April 5, 2011, Respondent issued additional prescriptions for oxycodone, alprazolam and temazepam.

60. On or about January 19, 2013, Patient B presented requesting a refill of oxycodone, stating her roommate's sister's brother stole her medications. Respondent issued the requested refills.

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[17] Temazepam, brand name Restoril, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Temazepam is a mid-acting benzodiazepine. When properly prescribed and indicated, it is commonly used to relieve anxiety.

[18] Ambien, brand name for zolpidem, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Ambien is a benzodiazepine analog. When properly prescribed and indicated, it is commonly used to treat insomnia.

61. On or about June 4, 2013, Patient B presented requesting an early refill of oxycodone stating she would be traveling to see her mother. Respondent issued the requested refills. At this point, Respondent was regularly prescribing to Patient B alprazolam (1 mg) four per day and oxycodone (30 mg) five per day.

62. On or about September 9, 2013, Patient B presented requesting an early refill of her oxycodone stating that she would be traveling out of town for one week. Respondent issued the requested refills, but noted a physical examination was overdue.

63. On or about December 9, 2013, Patient B presented requesting refills of both Adderall and oxycodone. Respondent notes Patient B has "gotten out of sync with the Adderall and the oxycodone" and issued the requested refills.

64. On or about June 25, 2014, Patient B was seen by a physician assistant, M.H., who refilled Patient B's medications and advised Patient B to wean her medications. On or about July 2, 2014, Respondent cosigned M.H.'s progress note.

65. On or about July 24, 2014, Patient B presented requesting refills on alprazolam, Adderall, and oxycodone. Progress notes for this visit indicate Respondent reviewed Patient B's pain management treatment during this visit and Patient B signed a pain contract.

66. On or about September 11, 2014, progress notes show Respondent received information from a pharmacy stating, "patient seeing, at least 2 doctors, and consuming 450, alprazolam, tablets, in approximately 3 months."

67. On or about October 21, 2014, Patient B presented for refills of medications, including, alprazolam, oxycodone and Adderall. Progress notes for this visit indicate Patient B was requesting handwritten prescriptions so she could check prices at different pharmacies, and wanted to discuss changing the dosage of alprazolam, as the current amount was no longer effective. Progress notes for this visit do not document any discussion between Respondent and Patient B regarding the information Respondent received from the pharmacy on September 11, 2014. At this visit, Respondent refilled Patient B's medications for Adderall (30 mg) two per day and oxycodone (30 mg) every four hours, as needed. Additionally, Respondent increased Patient

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B's alprazolam prescription from 4 mg per day (1 mg alprazolam four per day) to 6 mg per day (2 mg three per day).

68. When asked about this increase in dosage during a subject interview at the Department of Consumer Affairs Health Quality Investigation Unit, Respondent stated, "I don't remember making such a change... I rarely go over 4 (mg) a day."

69. On or about April 20, 2014, Patient B presented for refills of medications. Patient B was seen by physician assistant, M.H., who refilled Patient B's medications, and again, advised Patient B to wean her medications.

70. On or about October 12, 2015, Patient B presented for an office visit and was seen by Respondent who noted Patient B's anxiety "seems to be doing markedly better now...But we will increase the alprazolam to four times a day for the next month and dilate back down to three times a day when necessary." Respondent then issued a refill of Patient B's medications.

71. On or about January 18, 2016, February 19, 2016, and March 19, 2016, Patient B was seen by other physicians who counseled Patient B to reduce her alprazolam and contact Respondent to reconsider her use of opiates.

72. On or about March 29, 2016, Patient B presented for a routine visit. Progress notes for this visit indicate Respondent informed Patient B that "this amount of narcotic is out of [his] area of expertise." Respondent then issued a series of prescriptions of oxycodone "to effect a slow taper over about 2 weeks" including, oxycodone (30 mg) four per day for three days, oxycodone (30 mg) three per day for three days, oxycodone (20 mg) four per day for three days, oxycodone (20 mg) three per day for three days, oxycodone (15 mg) three per day for three days, then oxycodone (15 mg) two per day for three days.

73. On or about April 6, 2016, Respondent issued a patient termination letter terminating Patient B as his patient, stating, "I can no longer provide you with the care I believe your condition warrants, and thus my ability to care for you is compromised."

74. According to the CURES report for Patient B, from on or about November 2013 through on or about April 2016, Patient B was filling her prescriptions at approximately nine different pharmacies.

75. According to the CURES report for Patient B, from on or about November 2013 through on or about December 2015, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 3,450 tablets of oxycodone (30 mg).

76. According to the CURES report for Patient B, from on or about November 2013 through on or about October 2014, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 1,170 tablets of alprazolam (1 mg). Then, from on or about October 2015 through on or about November 2015, based upon prescription refills issued or authorized by Respondent, Patient B obtained approximately 1,280 tablets of alprazolam (2 mg).

77. According to the CURES report for Patient B, from on or about December 2013 through on or about January 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient B obtained approximately 1,418 tablets of Adderall (30 mg).

78. Respondent committed gross negligence in his care and treatment of Patient B, which included, but were not limited to, the following:

(a) Respondent failed to obtain and document informed consent prior to prescribing controlled substances to Patient B;

(b) Respondent failed to maintain a high degree of diligence for aberrant drug behavior and failed to recognize red flag behavior;

(c) Respondent failed to recognize dose escalation as a warning sign of aberrant drug behavior in Patient B;

(d) Respondent failed to take active steps to determine which medications Patient B was potentially receiving from other providers;

(e) Respondent failed to run toxicology screening tests of Patient B;

(f) Respondent failed to consider a progress note specifically stating not to provide early refills to Patient B and subsequently provided multiple early refills to Patient B;

(g) Respondent failed to respond appropriately to Patient B's reported theft of her medications;

(h) Respondent failed to respond appropriately to a phone call informing him of Patient B's excessive amounts of alprazolam and receiving prescriptions from more than one physician;

(i) Respondent failed to recognize when he doubled the strength of Patient B's alprazolam on October 21, 2014;

(j) Respondent failed to recognize the escalation of Patient B's alprazolam prescription;

(k) Respondent failed to adhere to his own ceiling dose or the standard maximum for prescribing alprazolam to Patient B;

(l) Respondent continually prescribed, for an extended period of time, a combination of benzodiazepines and opioids to Patient B without any documentation or plan to monitor for possible adverse events;

(m) Respondent failed to document or explain to Patient B his reasons for discontinuing the long-term opioid and benzodiazepine treatment;

(n) Respondent failed to provide Patient B information regarding specific behaviors which were impeding her care;

(o) Respondent failed to provide Patient B with a tapering dose of alprazolam;

(p) Respondent failed to provide any close clinical follow up care after discontinuing Patient B's benzodiazepines;

(q) Respondent failed to provide Patient B with a slow opiate taper, while documenting his intention to slowly taper Patient B's opiates;

(r) Respondent prescribed Patient B a rapid opioid taper;

(s) Respondent simultaneously discontinued Patient B's benzodiazepine without a taper while instituting a rapid opioid taper; and

(t) Respondent failed to support or document in his medical records the care and treatment provided to Patient B.

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Patient C

79. In or around 2012, Respondent began treating Patient C for, among other things, lower back pain, neck pain, synovitis,[19] thyroiditis,[20] and depression. From on or about 2012 through on or about 2016, Respondent prescribed several controlled substances to Patient C, including, but not limited to, fentanyl, alprazolam, Soma, diazepam,[21] and Butrans.[22]

80. During the period from on or about April 2013 through on or about August 2015, medical records show Patient C was issued medication refills approximately every month. During the period from on or about September 2015 through on or about December 2016, medical records show Patient C was issued medication refills approximately twice a month. In general, the progress notes for these visits are incomplete in that they lack adequate detail regarding medical indication for continued prescribing of controlled medications, treatment plan, or rationale for continued prescribing high amounts of fentanyl. Additionally, there is no documentation regarding informed consent prior to beginning treatment with controlled substances, there is no evidence Respondent was monitoring for aberrant behavior, and a patient-prescriber agreement form was not entered into until on or about May 2016.

81. On or about April 27, 2012, Patient C presented with complaints of severe pain among several other issues. Progress notes for this visit indicate Respondent performed an examination, discussed Patient C's presenting issues, and prescribed fentanyl patches (100 mcg) one patch every other day and Soma (350 mg) one or two per day.

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[19] Synovitis is an inflammation of the joint lining, synovial membrane. Symptoms are often short in duration and may change location, but may remain in one joint due to overuse.

[20] Thyroiditis is the inflammation of the thyroid gland. Hashimoto's thyroiditis, also known as chronic lymphocytic thyroiditis, often leads to an underactive thyroid gland, hypothyroidism.

[21] Diazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Diazepam is a long-acting benzodiazepine. When properly prescribed and indicated, it is used to treat anxiety, seizures and muscle spasms.

[22] Butrans is a brand name for buprenorphine, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Butrans is a long-acting opioid pain medication.

82. On or about August 10, 2012, Patient C presented for a follow up visit. Progress notes indicate Respondent prescribed fentanyl patches (100 mcg) one patch every other day and 60 tablets of Soma (350 mg) two per day with no documented discussion regarding Soma.

83. On or about October 1, 2012, Patient C presented for a follow up visit. Progress notes for this visit indicate Respondent prescribed fentanyl patches (100 mcg) one patch every other day and 240 tablets of Soma (350 mg) eight per day with no documented discussion regarding this increase in Soma. Respondent also prescribed Patient C baclofen[23] (10 mg) two per day, as needed.

84. On or about August 26, 2013, progress notes indicate a pharmacist called stating concerns regarding Patient C's drug usage and reported that Patient C was using multiple pharmacies.

85. On or about September 23, 2013, Patient C presented for follow up regarding neck pain and reported encountering issues in obtaining her medications. Progress notes for this visit do not document any discussion addressing Patient C's issues in obtaining her medications or her use of various pharmacies.

86. On or about October 11, 2013, progress notes indicate Respondent received a phone call from another physician, C.S., who stated a CURES report revealed Patient C had received a prescription from Respondent just two weeks after C.S. had prescribed to Patient C. Respondent indicated he would address this with Patient C at her next office visit.

86. On or about October 31, 2013, Patient C presented with complaints of ongoing neck pain. Progress notes for this visit indicate Patient C also informed Respondent that she has changed her name. When asked about using another physician, Patient C informed Respondent she was transitioning her care from physician C.S., to Respondent. Respondent then prescribed Patient C with 15 fentanyl patches (150-175 mcg) to be replaced every other day.

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[23] Baclofen is a dangerous drug pursuant to Business and Professions Code section 4022, commonly used as a muscle relaxant.

87. Despite Patient C's representation that she was transitioning her care from physician C.S. to Respondent, according to her CURES report, from on or about November 2013 through on or about January 2015, Patient C continued to receive and fill approximately 78 prescriptions for fentanyl issued by physician C.S., receiving a total of 490 fentanyl patches (75 mcg), 28 fentanyl patches (100 mcg), 8 fentanyl patches (5 mcg), and 4,099 fentanyl lozenges (800 mcg).

88. On or about November 4, 2013, Patient C presented requesting a new prescription for 10 additional fentanyl patches, stating the pharmacy only had five fentanyl patches available.

89. On or about November 12, 2013, Patient C presented regarding a urinary tract infection. Progress notes for this visit indicate Patient C's pharmacy only had 50 mcg fentanyl patches available. Respondent then issued a new prescription for 10 fentanyl patches (50 mcg) to be used two at a time every other day.

90. On or about November 13, 2013, progress notes indicate a pharmacist called stating concerns about the number of fentanyl prescriptions issued to Patient C and that the prescriptions were overlapping one another.

91. On or about November 14, 2013, progress notes indicate Respondent contacted the pharmacist and explained his intent to reduce Patient C's fentanyl dosage to 100 mcg and eventually to 75 mcg.

92. On or about December 9, 2013, Patient C presented for follow up regarding her neck pain. Progress notes for this visit indicate Patient C reported she had removed her fentanyl patches during surgery on a few occasions and now needed fentanyl patches for four additional days. Respondent noted his intent to reduce Patient C's fentanyl dose to 125 mcg, but then agreed to keep Patient C's fentanyl patch dose at 150 mcg for another month. Respondent then issued a prescription for five patches of fentanyl (75 mcg) to be used two at a time every other day.

93. On or about January 21, 2014, Patient C presented for medication refills. Progress notes for this visit indicate Patient C had decided to change pharmacies for financial reasons. Respondent refilled Patient C's prescriptions, including fentanyl patches (150 mcg) every other day, and Xanax, as needed, for anxiety.

94. On or about January 27, 2014, progress notes indicate another call from the pharmacy indicating Patient C had recently filled a 60-day prescription for fentanyl on December 26, 2013, and should still have a 30-day supply remaining.

95. On or about April 18, 2014, Patient C presented requesting refill of her medications. Progress notes for this visit indicate Patient C was specifically requesting refills of her fentanyl patches, but her records indicate she was not due for a refill until April 27, 2014. According to the progress notes, Respondent's plan was to review Patient C's CURES and refill Xanax and Soma. According to CURES, Patient C filled a prescription by Respondent for 30 tablets of alprazolam (Xanax) (0.5 mg), and 60 tablets of carisoprodol (Soma) (350 mg).

96. On or about September 19, 2014, progress notes indicate a call from the pharmacy, indicating Patient C has been filling prescriptions for fentanyl patches from physician C.S. Notes further indicate Patient C was informed she must obtain all her opiates from one source, C.S., and that Respondent would not fill or refill any opiate medications.

97. On or about September 22, 2014, progress notes indicate Respondent advised Patient C that he will continue to refill her prescriptions for Soma.

98. On or about February 3, 2015, Patient C presented requesting a referral for pain management since physician C.S. was reportedly no longer practicing pain management. Progress notes for this visit indicate Respondent was unsure whether he would be able to prescribe Actiq[24] and that Patient C would be "better served seeing a pain specialist given the severity of her problem, but we will cover her for now." Progress notes and Patient C's CURES report indicate Respondent then prescribed 30 tablets of alprazolam (0.5 mg), 30 patches of fentanyl (75 mcg), and 225 Actiq fentanyl lozenges (800 mcg).

99. On or about February 23, 2015, Patient C presented requesting a three months' supply of refills of her pain medication and trigger point injections for muscle spasms in her neck.

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[24] Actiq is a brand name for fentanyl citrate lozenges, a transmucosal immediate release fentanyl. In order to prescribe Actiq, prescribers must first enroll in the Transmucosal Immediate Release Fentanyl Risk Evaluation and Mitigation Strategy (TIRF REMS) program. For more information, see footnote 26 (below).

Progress notes for this visit indicate Respondent's plan to lower Patient C's total medicine dose. According to CURES and progress notes for this visit, Respondent issued prescriptions for 225 Actiq fentanyl lozenges (800 mcg), and fentanyl patches (75 mcg) to be used two at a time every other day over the next three months. The number of patches prescribed is not indicated in the progress notes. Progress notes further indicate Respondent also provided the requested trigger point injection.

100. On or about March 31, 2015, Patient C presented with complaints of abdomen swelling and tenderness. Progress notes for this visit indicate Respondent's plan to reduce Patient C's fentanyl dose. Respondent then issued prescriptions for 75 mcg fentanyl patches, 50 mcg fentanyl patches, and 240 Actiq fentanyl lozenges (1600 mcg).

101. From on or about February 2015 through November 2016, medical records indicate Patient C presented for visits on a monthly basis. Progress notes for these visits indicate Respondent's intent to reduce Patient C's fentanyl prescriptions. However, according to CURES and progress notes for these visits, Respondent continued to prescribe increasingly high amounts of fentanyl in various forms, including fentanyl patches at various levels, including 50 mcg, 75 mcg and 100 mcg, and Actiq fentanyl lozenges at various levels, including 800 mcg, 1200 mcg and 1600 mcg. Progress notes for these visits and CURES indicate Respondent reduced Patient C's fentanyl patch prescriptions while Respondent increased Patient C's prescriptions for Actiq fentanyl lozenges to control Patient C's pain.

102. From on or about February 2015, through on or about November 2016, according to CURES and progress notes for these visits, Patient C continued to receive and fill approximately 102 prescriptions for fentanyl patches and lozenges issued or authorized by Respondent.

103. From on or about December 2015 through on or about November 2016, according to CURES and progress notes, Respondent was prescribing to Patient C an average daily dose of 33,612 mcg of fentanyl per day.[25]

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[25] The maximum dose for fentanyl patches is 100 mcg per hour, a maximum of 2,400 mcg per day.

104. In or around December 2015 and January 2016, according to CURES and progress notes, Respondent was prescribing to Patient C an average daily dose of 54,400 mcg of fentanyl per day.

105. Despite Respondent's continued monthly prescribing of increasing amounts of Actiq fentanyl lozenges to Patient C, medical records show Respondent did not review a Transmucosal Immediate Relief Fentanyl Risk Evaluation and Mitigation Strategy (TIRF REMS) Access Patient Prescriber Agreement[26] (TIRF Agreement) with Patient C until on or about May 3, 2016. On or about May 3, 2016, Patient C signed the TIRF Agreement. On or about May 5, 2016, Respondent also signed the same TIRF Agreement.

106. The TIRF Agreement specifically states, in part, the Prescriber must sign this agreement form in order to receive TIRF medications, that TIRF medications are indicated only for the management of breakthrough pain in patients with cancer who are already receiving, and are already tolerant to, around-the-clock opioid therapy, that TIRF medications are contraindicated for use in opioid non-tolerant patients and that fatal overdose can occur at any dose, that patients using TIRF medications must also regularly use another around-the-clock opioid for constant pain, and if a patient stops taking around-the-clock opioid pain medicine, that the patient must also stop taking the TIRF medication.

107. When asked about his delayed enrollment in the TIRF REMS program during a subject interview at the Department of Consumer Affairs Health Quality Investigation Unit, Respondent first denied having completed the TIRF Agreement, then later explained that it was not part of his usual routine.

108. When asked about the lack of urine drug screens for Patient C during his subject interview, Respondent stated, "I had no suspicion that she was taking anything but opiates."

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[26] Transmucosal Immediate Relief Fentanyl (TIRF) is an extremely potent short acting opioid pain medication intended for use only for severe breakthrough pain in adult cancer patients who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain. TIRF is a fentanyl citrate lozenge on a stick, commonly known as fentanyl lozenges or fentanyl lollipops, brand name Actiq. The distribution of Actiq is restricted in the United States. All prescribers must enroll in the TIRF Risk Evaluation and Mitigation Strategy (REMS) program before being able to prescribe TIRF.

109. When asked about any concern for diversion, Respondent stated, "I would be stunned if she was doing such a thing...Because of her lifestyle."

110. At no time during his care and treatment of Patient C did Respondent document obtaining informed consent prior to treating Patient C with controlled substances.

111. At no time during his care and treatment of Patient C did Respondent recognize Patient C's aberrant drug behavior or document an adequate response to of Patient C's aberrant drug behavior.

112. According to the CURES report for Patient C, from on or about November 2013 through on or about November 2016, Patient C was filling her prescriptions at approximately six different pharmacies.

113. According to the CURES report for Patient C, from on or about February 2015 through on or about August 2015, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 65 patches of fentanyl (50 mcg).

114. According to the CURES report for Patient C, from on or about February 2015 through on or about August 2015, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 193 patches of fentanyl (75 mcg).

115. According to the CURES report for Patient C, from on or about February 2015 through on or about August 2015, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 75 patches of fentanyl (100 mcg).

116. According to the CURES report for Patient C, from on or about February 2015 through on or about November 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 7,980 fentanyl lozenges (800 mcg).

117. According to the CURES report for Patient C, from on or about February 2015 through on or about November 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 960 fentanyl lozenges (1200 mcg).

118. According to the CURES report for Patient C, from on or about February 2015 through on or about November 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 8,320 fentanyl lozenges (1600 mcg).

119. According to the CURES report for Patient C, from on or about November 2013 through on or about November 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 870 tablets of alprazolam (0.5 mg).

120. According to the CURES report for Patient C, from on or about November 2013 through on or about November 2016, based upon prescriptions and refills issued or authorized by Respondent, Patient C obtained approximately 420 tablets of carisoprodol (350 mg).

121. Respondent committed gross negligence in his care and treatment of Patient C, which included, but were not limited to, the following:

(a) Respondent failed to obtain and document informed consent prior to prescribing controlled substances;

(b) Respondent failed to maintain a high degree of diligence for aberrant drug behavior and failed to recognize red flag behavior;

(c) Respondent failed to take active steps to determine whether Patient C was receiving controlled substances from other providers;

(d) Respondent failed to discover Patient C was receiving care under two different names;

(e) Respondent failed to run toxicology screening tests on Patient C;

(f) Respondent failed to recognize dose escalation as a warning sign of aberrant drug behavior;

(g) Respondent escalated the dose of opioids to Patient C while documenting his intent to reduce the dose;

(h) Respondent failed to follow the standard of care in prescribing TIRF to Patient C;

(i) Respondent failed to maintain Patient C on a stable around-the-clock-opioid pain control regimen while continuing to prescribe TIRF to Patient C;

(j) Respondent prescribed TIRF to Patient C without the requisite training;

(k) Respondent failed to complete the necessary TIRF forms for approximately one year while prescribing TIRF to Patient C;

(l) Respondent prescribed TIRF to Patient C at a morphine equivalent of 7,500 mg per day;

(m) Respondent continually prescribed a combination of benzodiazepines and opioids to Patient C, without any documentation or plan to monitor for possible adverse events; and

(n) Respondent failed to support or document in his medical records the care and treatment provided to Patient C.

Patient D

122. According to the CURES report for Patient D, on or about October 23, 2013, Respondent issued a prescription for 60 tablets of Xanax (0.5 mg) two times a day, as needed, to Patient D.

123. No progress notes or patient chart was created to document any evaluation by Respondent, medical indications for prescribing Xanax to Patient D, or Respondent's reasoning for the dose prescribed to Patient D.

124. Respondent committed gross negligence in his care and treatment of Patient D, which included, but were not limited to, the following:

(a) Respondent failed to document his reasoning for prescribing Xanax to Patient D at a dose of 1.0 mg per day, when Patient D was benzodiazepine naïve; and

(b) Respondent failed to create and keep a medical record documenting his treatment of Patient D.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

125. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 42137 to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C and D, as more particularly alleged hereinafter:

(a) Paragraphs 9 through 124, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent prescribed Xanax to Patient D without clear medical indication.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

126. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 42137 to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (d), of the Code, in that he demonstrated incompetence in his care and treatment of Patients B and D, as more particularly alleged hereinafter:

Patient B

127. Paragraphs 56 through 78, above, are hereby incorporated by reference and realleged as if fully set forth herein.

128. From 2013 through 2016, Respondent was regularly prescribing to Patient B a high dose of both benzodiazepines and opioids, including alprazolam (1 mg) four times per day and oxycodone (30 mg) four or five times per day to Patient B.

129. On or about March 29, 2016, Respondent issued oxycodone prescriptions to Patient B instituting an extremely rapid taper of Patient B's oxycodone 150 mg per day regimen. Respondent issued a prescription for 120 mg per day for three days (20% taper), 90 mg per day for three days (25% taper), 80 mg per day for three days (11% taper), 60 mg per day for three days (25% taper), 45 mg per day for three days (25% taper), then 30 mg per day (33% taper). In total,

Respondent had prescribed an 80% reduction of Patient B's oxycodone over the course of 18 days.[27]

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[27] "A gradual taper pace of reducing opioid dosage by 5-20% every four (4) weeks with the option to pause periodically allows time for neurobiological equilibration as well as the acquisition of new skills to manage pain and emotional distress. In some patients, a faster taper may be needed when risks are too high to consider a gradual taper; consider tapering the dose by 5-20% per week in this patient population. Regardless of the initial speed of taper, the pace of taper should be revaluated frequently and adjusted as needed to maximize safety and patient comfort as safety allows. (VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, Clinician Summary, pg. 22.)

130. When asked about this prescribing pattern during a subject interview at the Department of Consumer Affairs Health Quality Investigation Unit, Respondent described this tapering regimen as a "slow taper."

131. Respondent's failure to recognize his opioid taper as prescribed to Patient B as a rapid taper demonstrates Respondent's lack of knowledge of the safe discontinuation of long-term opioid treatment.

Patient D

132. Paragraphs 122 through 124, above, are hereby incorporated by reference and realleged as if fully set forth herein.

133. On or about October 23, 2013, Respondent prescribed 60 tablets of Xanax (0.5 mg) to Patient D to be taken two per day (1 mg per day). When asked about why he issued this prescription during a subject interview at the Department of Consumer Affairs Health Quality Investigation Unit, Respondent stated it was for travel related situational anxiety.

134. To issue a one-month supply of 1 mg of Xanax per day to Patient D, who was benzodiazepine naïve for situational travel anxiety, Respondent demonstrated lack of knowledge of the safe and effective use of benzodiazepines.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without an Appropriate Prior Examination or Medical Indication)

135. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 42137 to disciplinary action under sections 2227, and 2234, as defined by 2242, of the Code, in that he prescribed, dispensed, or furnished dangerous drugs as defined in section 4022 without an appropriate medical indication, in his care and treatment of Patient D, as more particularly alleged in paragraphs 122 through 124, and 132 through 134, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

136. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 42137 to disciplinary action under sections 2227 and 2234, as defined by 2266, of the Code, in

that he failed to keep adequate and accurate medical records in his care and treatment of Patients A, B, C and D, as more particularly alleged in paragraphs 9 through 135, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Violation or Violations of the Medical Practice Act)

137. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 42137 to disciplinary action under sections 2227 and 2234, as defined by 2234, subdivision (a), of the Code, in that he committed a violation or violations of a provision or provisions of the Medical Practice Act in his care and treatment of patients A, B, C and D, as more particularly alleged in paragraphs 9 through 136, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 42137, issued to Respondent Philip Albert Sanderson, M.D.;

2. Revoking, suspending or denying approval of Respondent Philip Albert Sanderson, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Philip Albert Sanderson, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 6, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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